Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

# General

## Title

Language services: the percent of patient visits and admissions where preferred spoken language for health care is screened and recorded.

## Source(s)

Robert Wood Johnson Foundation. Aligning forces for quality. Language services performance measures implementation guide, version 1.1. Washington (DC): George Washington University; 2009 Aug. 84 p.

# Measure Domain

## Primary Measure Domain

Clinical Quality Measures: Process

## Secondary Measure Domain

Does not apply to this measure

# Brief Abstract

## Description

This measure is used to assess the percent of patient visits and admissions where preferred spoken language for health care is screened and recorded.

## Rationale

Hospitals cannot provide adequate and appropriate language services to their patients if they do not create mechanisms to screen for limited English-proficient patients and record patients' preferred spoken language for health care. Standard practices of collecting preferred spoken language for health care would assist hospitals in planning for demand. Access to and availability of patient language preference is critical for providers in planning care. This measure provides information on the extent to which patients are asked about the language they prefer to receive care in and the extent to which this information is recorded.

## Evidence for Rationale

Robert Wood Johnson Foundation. Aligning forces for quality. Language services performance measures implementation guide, version 1.1. Washington (DC): George Washington University; 2009 Aug. 84 p.

## Primary Health Components

Limited English proficiency (LEP); preferred spoken language; screening

## Denominator Description

The total number of hospital admissions, visits to the emergency department, and outpatient visits (see the related "Denominator Inclusions/Exclusions" field)

## Numerator Description

The number of hospital admissions, visits to the emergency department, and outpatient visits where preferred spoken language for health care is screened and recorded (see the related "Numerator Inclusions/Exclusions" field)

# Evidence Supporting the Measure

## Type of Evidence Supporting the Criterion of Quality for the Measure

A formal consensus procedure, involving experts in relevant clinical, methodological, public health and organizational sciences

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

## Additional Information Supporting Need for the Measure

- 22.3 million U.S. residents (8.4%) have limited English proficiency (LEP).
- Between 1990 and 2000, the number with LEP grew by 53%.
- 80% of hospitals reported treating LEP patients on a regular basis.
- Hispanics who do not speak English at home are less likely to receive all recommended health care services.
- Follow-up compliance, adherence to medications, and patient satisfaction are significantly lower for LEP populations than they are for English speaking patients.
- Language barriers are associated with less health education, worse interpersonal care, and lower patient satisfaction.
- LEP populations are less likely to receive preventative health services such as mammograms.
- Persons with LEP experience disproportionately high rates of infectious disease and infant mortality.
- Persons with LEP are more likely to report risk factors for serious and chronic diseases such as diabetes and heart disease.
- Physicians who are unable to communicate effectively with their patients often compensate by engaging in costly practices such as: more diagnostic procedures; more invasive procedures; overprescribing medications.
- Language barrier between physicians and their patients are associated with a $38 increase in test charges and 20-minute longer emergency department (ED) stay.

- ED decision making behavior (e.g., diagnostic testing, admission, IV hydration) is more costly when non-English speaking patients did not receive care from bilingual physician or with an interpreter present.
- The average cost per interpretation for health maintenance organizations (HMOs) patients was $79 and the total cost per year was $279, a relatively small cost given total medical expenditures, and given improved patient utilization of preventive and primary care services that may reduce long-term medical costs.

## Evidence for Additional Information Supporting Need for the Measure


Andrulis D, Goodman N, Pryor N. What a difference an interpreter can make: health care experiences of uninsured with limited English proficiency. The Access Project; 2003 Apr.

Cheng EM, Chen A, Cunningham W. Primary language and receipt of recommended health care among Hispanics in the United States. J Gen Intern Med. 2007 Nov;22 Suppl 2:283-8. PubMed

David RA, Rhee M. The impact of language as a barrier to effective health care in an underserved urban Hispanic community. Mt Sinai J Med. 1998 Oct-Nov;65(5-6):393-7. PubMed

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Ku L, Waidmann T. How race/ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2003 Aug. 29 p.

Ngo-Metzger Q, Sorkin DH, Phillips RS, Greenfield S, Massagli MP, Clarridge B, Kaplan SH. Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use. J Gen Intern Med. 2007 Nov;22 Suppl 2:324-30. PubMed

Office of Minority Health and Health Disparities. Eliminating racial and ethnic disparities.

U.S. Bureau of the Census. American Community Survey: language spoken at home (table S1601). 2005.

Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services. J Gen Intern Med. 1997 Aug;12(8):472-7. PubMed

### Extent of Measure Testing

The measure was pilot tested in one inpatient and in one outpatient care setting in two (2) large metropolitan hospitals October 2006.

The measure was used by the 10 grantee hospitals in the Speaking Together National Language Services Collaborative from November 2006 - May 2008. Ten (10) hospitals reported data monthly on 40,000 - 60,000 patients seen in inpatient and ambulatory care settings. Hospitals ranged in size from 11,500 - 44,000 admissions, included 2 children's hospitals and were comprised of both academic teaching and non-teaching community hospitals.

The measures specifications were revised based on the learning from the Speaking Together Collaborative and input from the participating hospitals.

Refer to original measure documentation for additional information.

### Evidence for Extent of Measure Testing

Robert Wood Johnson Foundation. Aligning forces for quality. Language services performance measures implementation guide, version 1.1. Washington (DC): George Washington University; 2009 Aug. 84 p.

## State of Use of the Measure

### State of Use

Current routine use

### Current Use

not defined yet

## Application of the Measure in its Current Use

### Measurement Setting

Emergency Department

Hospital Inpatient

Hospital Outpatient

### Professionals Involved in Delivery of Health Services

not defined yet

### Least Aggregated Level of Services Delivery Addressed

Clinical Practice or Public Health Sites

### Statement of Acceptable Minimum Sample Size

Does not apply to this measure

### Target Population Age

All ages

### Target Population Gender

Either male or female

## National Strategy for Quality Improvement in Health Care

### National Quality Strategy Aim

Better Care

### National Quality Strategy Priority

Health and Well-being of Communities
Person- and Family-centered Care
Prevention and Treatment of Leading Causes of Mortality

## Institute of Medicine (IOM) National Health Care Quality Report Categories

### IOM Care Need

Getting Better

Living with Illness

Staying Healthy

### IOM Domain

Effectiveness

Equity

Patient-centeredness

# Data Collection for the Measure

## Case Finding Period

Unspecified

## Denominator Sampling Frame

Patients associated with provider

## Denominator (Index) Event or Characteristic

Encounter

Institutionalization

## Denominator Time Window

not defined yet

## Denominator Inclusions/Exclusions

Inclusions
The total number of hospital admissions, visits to the emergency department, and outpatient visits, including:

- Scheduled and unscheduled visits
- Elective, urgent and emergent admissions
- Short stay and observation patients
- Transfers from other facilities

Exclusions
None

## Exclusions/Exceptions

not defined yet

## Numerator Inclusions/Exclusions

Inclusions
The number of hospital admissions, visits to the emergency department, and outpatient visits where preferred spoken language for health care is screened and recorded, including:

- Admissions and visits where the patient's preferred language for health care is recorded
- Admissions and visits where the patient declined to answer the screening question

Notes:

- The admissions and visits are stratified by language, including English, decline, or unavailable.
- American Sign Language should be included as a preferred spoken language for health care for this measure.

Exclusions

Admissions and visits where the spoken language preference data is not recorded

### Numerator Search Strategy

Fixed time period or point in time

### Data Source

Administrative clinical data

Paper medical record

Registry data

### Type of Health State

Does not apply to this measure

### Instruments Used and/or Associated with the Measure

Health Research and Educational Trust Disparities Toolkit

## Computation of the Measure

### Measure Specifies Disaggregation

Does not apply to this measure

### Scoring

Rate/Proportion

### Interpretation of Score

Desired value is a higher score

### Allowance for Patient or Population Factors

not defined yet

### Description of Allowance for Patient or Population Factors

Data reported as aggregate numerator and denominator, monthly, stratified by spoken language preference, including English, decline or unavailable.

Non-English Speaking Populations can be identified from screening to determine if needed language services were delivered. Clinical performance measures can be stratified by language to examine whether disparities exist among varying language groups.

## Standard of Comparison

not defined yet

# Identifying Information

## Original Title

L1A: screening for preferred spoken language for health care.

## Measure Collection Name

Language Services Performance Measures

## Submitter

Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services - Academic Affiliated Research Institute

## Developer

Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services - Academic Affiliated Research Institute

## Funding Source(s)

Robert Wood Johnson Foundation

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## Financial Disclosures/Other Potential Conflicts of Interest

No disclosures.

## Adaptation

This measure was not adapted from another source.

## Date of Most Current Version in NQMC

2009 Aug

## Measure Maintenance

Unspecified

## Date of Next Anticipated Revision

Unspecified

## Measure Status

This is the current release of the measure.

The measure developer reaffirmed the currency of this measure in December 2015.

## Measure Availability

Source not available electronically.

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## NQMC Status

This NQMC summary was completed by ECRI Institute on May 17, 2010. The information was verified by the measure developer on July 2, 2010.

This NQMC summary was retrofitted into the new template on July 29, 2011.

The information was reaffirmed by the measure developer on December 22, 2015.

## Copyright Statement



# Production

## Source(s)

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# Disclaimer

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